STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
RAMENTC, CA 95814
(916) 445-1797

September 7, 1979

To: All County Welfare Directors Letter No. 79-22

MEDI-CAL SHARE-OF-COST PROCESSING DUE TO ANNUAL CHANGES IN ALLOWED INCOME AMOUNTS

This letter supplements and updates Medi-Cal All County Letter No. 79-18 of July 30. Three of the items below deal exclusively with the effects of annual income amount changes on share-of-cost computations and income verification. The other two deal with processing for share-of-cost cases in general; but they have particular application to cases affected by the annual changes.

SHARE-OF-COST COMPUTATION WHEN A FAMILY MEMBER IS RECEIVING SSI/SSP

The California SSI/SSP payment levels for fiscal year 1979/80 have been determined sufficient to meet federal "food stamp cash-out" standards. This means California no longer must provide food stamps, or cash in lieu of food stamps, to SSI/SSP recipients. Accordingly, September 1979 will be the last month in which the SSI/SSP recipients described in Letter No. 79-1 of January 19, 1979, will receive the additional "$10 in lieu of food stamps" payment in their gold SSI/SSP check. Therefore, effective with October share-of-cost computations, in all cases which require completion of PART III, MC 176 W, the actual amount of the gold SSI/SSP check should be used in the computation.

MEDI-CAL QUALITY CONTROL (MQC) IMPLEMENTATION OF 1979/80 COST OF LIVING INCREASES

Effective with the November 1979 month of eligibility, the 1979/80 Medi-Cal allowed income amounts transmitted in Letter No. 79-18 will be applied in all MQC reviews. In addition, the retroactive recomputations described in Letter No. 79-18 must be completed by December 31, 1979 in order to prevent MQC errors from being cited.

MC 177 SUBMISSION TO BENEFITS REVIEW UNIT

This is to advise that effective immediately, Record of Health Care Cost Forms (MC 177) should not be batched by current and past months before submission to the Department of Health Services' Benefits Review Unit (BRU). As you recall, this batching system was implemented to expedite current month MC 177 processing while BRU was backlogged. Since BRU processing of MC 177s is current now, this batching is no longer necessary.

SHARE OF COST ADJUSTMENT PROCEDURES

Attached is an advance copy of procedures for handling a Medi-Cal-only case in which the share of cost for a past month has been retroactively

lowered, where the case members choose past month reimbursement rather than a lower future share of cost. The procedures explain the steps required of the parties involved -- beneficiaries, counties, providers, BRU, and the Medi-Cal intermediary -- to complete the reimbursement process. The procedures also explain how a future-month MC 176 M should reflect a reduced share of cost, if that adjustment option is chosen. These procedures will appear in the next Medi-Cal Eligibility Manual update.

VERIFICATION OF SOCIAL SECURITY TITLE II INCOME

We have been advised that some eligibility staff are asking local Social Security district offices to manually verify the new amounts of Social Security Title II income which affected Medi-Cal-only eligibles started receiving in July. This should not be done for:

1. Eligibles whose current Title II income was calculated from instructions in Medi-Cal All-County Directors' Letter No. 79-13. That letter provided the verification required by Medi-Cal regulations, since the instructions were based on information from the Social Security Administration;

2. Eligibles who are entitled to state Medicare buy-in (i.e., eligibles 65 or over or eligibles who already have Medicare). Title II income verification for this group is provided by the state's BENDEX system reports.

Due to state data processing problems, the Department is currently unable to send BENDEX data in computer tape form to those counties who normally produce their own reports from those tapes. Department staff are working to get these problems resolved as quickly as possible. In the interim, state-printed BENDEX reports are being sent to the affected counties. We recognize that the differences between state and county reports may limit counties' ability to use the interim state reports; however, counties should use those reports for income verification to the extent feasible. Medi-Cal-only cases, whose Title II income amounts cannot be verified until receipt of normal BENDEX data, are not considered to be in conflict with income verification provisions of Medi-Cal regulations.

It is appropriate to request Title II income verification from SSA district offices, via form SSA 1610 or other method, for persons newly eligible since July who are not entitled to state buy-in, if the persons cannot directly provide that verification.

COST OF LIVING IMPLEMENTATION SCHEDULE

Any county unable to meet the cost of living increases implementation schedule set forth in this letter must advise its Department of Health Services Medi-Cal field representative in writing by October 1, 1979. This notification must include an explanation for the county's inability to comply with the schedule.

If you have any questions or comments regarding this information, please contact your Department of Health Services Medi-Cal field representative.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Eligibility Branch

Attachment
cc: Medi-Cal Liaisons
Medi-Cal Field Representatives

Expiration Date: March 31, 1980

Article 10 J
Processing Cases When a Share of Cost Has Been Reduced Retroactively

A. Background

California Administrative Code (CAC), Title 22, Sections 50565 and 50567, discuss the options available to eligible persons determined, after recomputation, to have a lower Medi-Cal share of cost for a given month than was originally computed. Such a person has the option of:

1. Having future share-of-cost amounts adjusted by the county; or

2. Adjusting with providers, the amounts obligated or paid to those providers to meet the overstated portion of the original share of cost.

If an individual is seeking an adjustment of a future share of cost and transfers to another county prior to receiving the full adjustment, the old county of responsibility must inform the new county of the adjustment amount that is still due.

Beneficiaries whose future share of cost is zero before an adjustment is applied, must be advised that the only recourse is to seek reimbursement from the provider. In any situation where a beneficiary chooses to seek reimbursement from a provider, it must first be determined whether the provider has billed Medi-Cal for any portion of the service for which reimbursement is requested. This may be determined by reviewing the original MC 177. If the "Total Bill" amount is greater than the "Patient Billed" amount or if there is an amount shown in the "Billed Medi-Cal" column, it should be assumed that the provider <u>has</u> billed Medi-Cal. If the "Billed Medi-Cal" column is blank or the "Billed Patient" column is equal to the "Total Bill" column, it should be assumed that the provider <u>has not</u> previously billed the Medi-Cal program.

Prior to seeking reimbursement from the provider, clients shall be instructed by the county to give the provider a revised MC 177-S and a "Share of Cost Medi-Cal Provider Letter" so that the provider may bill the Medi-Cal program and reimburse the client the appropriate share-of-cost amount. If the county or the client is in possession of the original MC 177-S, the county may modify that form rather than prepare a revised one. The "Share of Cost Medi-Cal Provider Letter" will explain the reimbursement and billing procedures and the recomputation of the share of cost (see example-Attachment II). So that the provider may be informed of the proper procedures to follow, counties shall check the box appropriate to the client's situation.

The form may be ordered through the normal Department forms ordering process described in the forms section of the Medi-Cal Eligibility Manual, page F-1, beginning September 30. Until that time, the form may be reproduced.

Individuals needing a Medi-Cal identification card in order to accomplish the adjustment process should be given proof of eligibility (POE) labels only, except for individuals who did not meet their original share-of-cost. Those beneficiaries who did not meet their original share of cost will receive a full complement card from Benefits Review Unit (BRU) when the MC 177 is completed and processed. If any individual used services to meet the share of cost which would require a "MEDI" label, the provider may use the POE label, along with the "Share of Cost Medi-Cal Provider Letter" to bill the program. This letter will alert the fiscal intermediary that the case is being adjusted and to waive the "MEDI" label requirement for the specific services listed on the claim; in addition a Treatment Authorization Request (TAR) will not be necessary for claims submitted with this letter for services normally requiring a TAR.

B. Case Situations

The following procedures describe the adjustment process and the different methods for working with various case situations in recomputing the share of cost.

Adjustment of Share-of-Cost Amount

Case Situation 1 -- Client was determined eligible for July with a share of cost and met the share of cost. It is later determined that the July share of cost should have been lower. Client requests adjustment of future share-of-cost amounts.

Case Processing Steps

a. The county shall recompute the July share of cost and prepare a new MC 176-M (latest revision) for the case file. (The difference between the original and recomputed share of cost for July is the amount of the adjustment.)

b. On the MC 176-M, for August (the future month in which the share of cost is to be adjusted) enter the August share-of-cost amount in Column III, line 17, and enter the amount of the adjustment in line 18. Subtract line 18 from line 17 to determine the new adjusted share-of-cost amount (see example-Attachment III) and enter the amount in line 19. If the amount of the adjustment (line 18) is greater than the August share-of-cost amount (line 17) the client is not required to meet a share of cost for August. If necessary, repeat this step for subsequent months until the entire adjustment is made.

c. For the August and other future months' eligibility the county shall prepare an MC 177-S showing the adjusted share-of-cost amount and submit to the client (see example-Attachment IV). The MC 177-S must be completed by the provider showing the amount of the new adjusted share of cost for which the client is responsible.

d. Upon completion of the MC 177-S by the provider, the client must sign and return the form to the county, which in turn, shall send it along with the revised MC 176-M to: Department of Health Services, Benefits Review Unit, P. O. Box 668, Sacramento, CA 95803 for card issuance.

Case Situation 2 -- Client was determined eligible for October with a share of cost, but did not meet the share-of-cost amount in full. It is later determined that the October share of cost should have been lower. Client requests adjustment of the future share of cost.

Case Processing Steps

a. Obtain documentation from the client of the amount that was paid or obligated toward services received in October (documentation may be cancelled checks, a statement of charges from the provider, or the original MC 177-S for October showing amounts paid or obligated to the provider). If no documentation exists, the client may choose to have the provider complete a new MC 177-S.

b. If it is determined that the client paid or obligated more than the recomputed October share of cost, the difference between the amount paid or obligated and the recomputed share of cost will be the amount to be adjusted (e.g., client's original share of cost is $100.00, client paid $75.00; the recomputed share of cost is $50.00, the amount to be adjusted for future months is $25.00).

c. Process case according to steps listed for items a-e in Case Situation 1. The client should be provided a new MC 177-S for each month in question, indicating the adjusted share of cost.

d. If the amount already paid or obligated in October is less than the recomputed October share of cost, no adjustment is necessary.

Provider Reimbursement of Share-of-Cost Amount

Case Situation 3 -- Client was determined eligible in November with a share of cost and met the share of cost. A recomputation indicates the share-of-cost should have been zero. Client wants a reimbursement of the share-of-cost amount paid to the provider(s). The provider(s) billed Medi-Cal for a portion of the service(s).

Case Processing Steps

a. The county shall recompute the November share of cost and prepare the MC 176-M for the case file.

b. The county shall also prepare a "Share of Cost Medi-Cal Provider Letter" explaining the November share-of-cost adjustment, give it to the client, and send a copy to BRU for its record.

c. The client should give the "Share of Cost Medi-Cal Provider Letter" to the provider.

d. The provider should then submit a claim along with a copy of the letter to the appropriate Medi-Cal fiscal intermediary (FI).

e. The FI will reimburse the provider the appropriate adjusted amount.

f. The provider(s) should then pass the difference in the share-of-cost amount on to the client.

Case Situation 4 -- Client was determined eligible in September with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been lower. Client wants reimbursement for the excess share-of-cost amount paid. The provider(s) billed Medi-Cal for a portion of the service(s).

Case Processing Steps

a. The county shall recompute the September share of cost and prepare the MC 176-M for the case file.

b. The county shall also prepare a revised MC 177-S showing the recomputed September share-of-cost amount and give it to the client along with a completed copy of the "Share of Cost Medi-Cal Provider Letter".

c. The client should submit to the provider form MC 177-S and the "Share of Cost Medi-Cal Provider Letter" which explain the adjustments made.

d. Upon completion of the MC 177-S by the provider, the client must sign and return the form to the county.

e. The county will send form MC 177-S and a copy of the recomputed MC 176-M to Department of Health Services, BRU.

f. BRU will adjust any previous claims submitted by the providers and return the claims to the FI.

g. The FI will reimburse the provider the appropriate amount.

h. Providers should then pass the difference in the share-of-cost amount on to the client.

Case Situation 5 -- Client was determined eligible in January to have a share of cost and met the share of cost. A recomputation indicates the share of cost should have been lower. Client wants a reimbursement of the excess share-of-cost amount previously paid. Client's provider(s) did not previously bill the Medi-Cal program.

Case Processing Steps

a. For processing MC forms 176-M and 177-S follow steps a-e in Case Situation 4.

b. BRU will request preparation of a Medi-Cal card with POE labels only. The card will be mailed directly to the client by the Department of Health Services.

c. The client should return the POE labels to the provider who should reimburse the client and use the labels to bill the program.

Case Situation 6 -- Client was determined eligible in June with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been zero. Client wants a reimbursement of the share-of-cost amount paid to the provider(s). The provider(s) did not previously bill the Medi-Cal program.

Case Processing Steps

a. The county shall recompute the June share of cost, prepare the MC 176-M for the case file and send a copy to BRU for its records.

b. The county shall prepare for the client the "Share of Cost Medi-Cal Provider Letter" explaining the June share-of-cost adjustment and issue the client a POE only Medi-Cal card or request that one be issued by BRU via form MC 110.

c. The client should present the Medi-Cal card and the "Share of Cost Medi-Cal Provider Letter" to the provider.

d. The provider should then submit a claim with the Medi-Cal label attached along with a copy of this letter to the Medi-Cal FI.

e. The FI will reimburse the provider the appropriate amount.

f. The provider(s) should then pass the difference in the share-of-cost amount on to the client.

C. Submitting Revised MC 176-M and MC 177-S Forms to Department of Health Services

In order to ensure proper processing of recomputed share-of-cost cases by BRU, it will be necessary for county welfare departments to properly identify these cases. The following procedures shall be followed:

1. In case situations where the provider has billed the Medi-Cal program previously and the client still, after recomputation, has a share of cost; and does not want a reimbursement, counties shall indicate at the top of the revised MC 177-S "Adjustment -- Billed" (See Attachment IV).

2. In case situations where the provider has billed the Medi-Cal program, the client, after recomputation, has a lower share of cost and wants a reimbursement, the county shall indicate on the top of the revised MC 177-S "Adjust Previous Claims" (See Attachment V).

3. In case situations where the client met the share of cost and the provider did not bill the program because the share of cost equaled the amount of the bill, and the client, after recomputation, has a lower share of cost, the county shall indicate at the top of the MC 177-S -- "Adjustment -- Not Billed" (See Attachment VI). For these cases, BRU will prepare a Medi-Cal identification card, POE labels only, and mail it directly to the beneficiary.

4. In case situations where the client met the share of cost, the recomputed share of cost is zero and the provider did not previously bill the program, the county shall indicate at the top of the MC 176-M -- "Adjustment -- Not Billed Zero Share of Cost". If requested by the county, BRU will prepare a Medi-Cal card, POE labels only, and mail it directly to the beneficiary.

5. In case situations where the client did not meet the original share of cost in part or in full, and the client still, after recomputation, has a share of cost, the county shall process the case using the current MC 177-S procedures described in Section 12A of the Medi-Cal Eligibility Manual. When the MC 177-S is received by BRU, a full complement Medi-Cal identification card will be issued and sent directly to the beneficiary.

County welfare departments must "batch" the MC 177-S forms separately for each of the specific case situations described. These "batches" should not be combined with regular share-of-cost cases being sent to BRU except for those cases described in number 5 above. To expedite processing of recomputed share-of-cost cases and to ensure proper processing, it is extremely important that these procedures be followed.

ADJUSTMENTS OF SHARE OF COST AND PROVIDER REIMBURSEMENT

Summary Chart

Case Situation	Case Processing				
	Prepare new 176 for case file and/or BRU	Prepare 177 for provider completion	Give "Share of Cost Medi-Cal Provider Letter" to Provider	Send 177/176 to BRU	County or BRU preparation of Medi-Cal ID card
1. Client <u>met</u> original share of cost. Share of cost should be <u>lower</u>. Client requests adjustment of future share of cost amounts.	X	X		X	
2. Client <u>did not meet</u> original share of cost. Share of cost should be <u>lower</u>. Client requests adjustment of share-of-cost amount.	X	X		X	
3. Client <u>met</u> original share of cost. Share of cost should have been <u>zero</u>. Provider(s) billed Medi-Cal. Client requests reimbursement from provider.	X		X	X	

ADJUSTMENTS OF S. .E OF COST
AND PROVIDER REIMBURSEMENT

Summary Chart

	Case Situation	Case Processing				
		Prepare new 176 for case file and/or BRU	Prepare 177 for provider completion	Give "Share of Cost Medi-Cal Provider Letter" to Provider	Send 177/176 to BRU	County or BRU preparation of Medi-Cal ID card
4.	Client met original share of cost. Share of cost should have been lower. Provider(s) billed Medi-Cal. Client requests reimbursement from provider.	X	X	X	X	
5.	Client met original share of cost. Share of cost should have been lower. Provider(s) did not bill Medi-Cal. Client requests reimbursement from provider.	X	X	X	X	X (POE labels only)
6.	Client met original share of cost. Share of cost should have been zero. Provider(s) did not bill Medi-Cal. Client requests reimbursement from provider.	X		X	X	X (POE labels only)

ATTACHMENT II

Share of Cost Medi-Cal Provider Letter

To: Medi-Cal Provider

Subject: Applicant's Name

The individual(s) shown above had been determined eligible for Medi-Cal for the month(s) of _____ with a monthly share of cost of _____. Upon review, it has been determined that the share of cost for the month(s) indicated should have been only _____. Accordingly, the beneficiary is due a reimbursement of the difference between the share-of-cost amount paid to you and the recomputed share of cost. This amount must be passed along to the beneficiary by the provider in accordance with California Administrative Code (CAC), Title 22, Section 51471.1. The following information is to assist you in making the required reimbursement.

If the beneficiary actually paid the original share-of-cost amount to you and you billed Medi-Cal for the balance of the charges, you may be eligible to receive an adjustment from the Medi-Cal fiscal intermediary. Once you have billed the program, you are obligated to pay the beneficiary the excess share-of-cost amount previously paid to you.

If the beneficiary actually paid the original share-of-cost amount to you, and you did not bill the program because the charges equaled the original share-of-cost amount, you may now bill the program for the difference between your usual fee and the recomputed share of cost. Again, you are obligated to pay the beneficiary the excess share-of-cost amount previously paid to you.

If the beneficiary has not paid, but obligated to pay the original share of cost, the new adjusted amount should be used to reduce the obligation.

If you were unable to bill the program because the beneficiary had not paid or obligated the full amount of the original share of cost, you may now do so by submitting this form and a claim with a Medi-Cal label to the Medi-Cal fiscal intermediary.

The items checked below must be accomplished in order to complete the reimbursement process.

☐ Complete the MC 177-S based on the revised share-of-cost amount. If the beneficiary meets the recomputed share of cost, he/she will be issued a Medi-Cal card. Any outstanding balance may be billed to Medi-Cal.

☐ It is not necessary for you to rebill the Medi-Cal program for the services listed on the MC 177-S. An adjustment to your previous claim will be made by Department of Health Services.

☐ It will be necessary for you to bill the Medi-Cal program. You must attach this form letter to your claim. The beneficiary listed above is responsible for presenting you with a Medi-Cal identification card or label to attach to your claim. If you are billing the Medi-Cal program and you rendered a service requiring a MEDI label or "prior authorization", this form, along with the Medi-Cal identification card (POE) label attached to your claim, will allow the fiscal intermediary to process the claim without those items.

ATTACHMENT III

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

ADJUSTED SHARE OF COST

DEPARTMENT OF HEALTH SERVICES

SHARE OF COST DETERMINATION — MN AND MI PERSONS

CASE NAME

COUNTY DISTRICT | COUNTY USE

☐ New APPLICATION ☐ REDETERMINATION ☐ CHANGE ☐ RETROACTIVE ELIG. ☒ CORRECTION

EFFECTIVE ELIGIBILITY DATE FOR THIS BUDGET MO. YR.

State Number Co.	Aid	7 Digit Serial No.	MFBU	Pers. No.	Name — First, Middle, Last	Birthdate Mo Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No or Railroad Retirement No	Other Coverage
2314		0000000	0	50	Helen Of Troy	1/20/19	F	(1) 543-16-0000 (2)	A
2314		0000000	0	60	William Of Troy	7/5/13	M	(1) 561-42-0000 (2)	A
								(1) (2)	
								(1) (2)	
								(1) (2)	
								(1) (2)	
								(1) (2)	

I. INCOME OF MFBU MEMBERS APPLYING AS AGED, BLIND, OR DISABLED PLUS INCOME OF SPOUSE OR PARENT (EXCEPT PA OR OTHER PA)

A. NONEXEMPT UNEARNED INCOME

	a. ABD - MN	b. Spouse or parent
1. Social Security		
2. Net Income from Property		
3. Other — Itemize		
4.		
5. Total (add 1 through 4)		
6. Deductions		
7. Remainder (5 minus 6)	a.	b.
8. Combined unearned inc (add 7a and 7b)		
9. Any income deduction	—$20	
10. Countable unearned income (8 minus 9)		

B. NONEXEMPT EARNED INCOME

	a.	b.
1. Gross Earned Income		1,500
2. Deductions		100
3. Remainder (11 minus 12)	a.	b. 1,400
4. Combined earned inc. (add 13a and 13b)		
5. $65 earned inc deduction plus $_____ unused $20		85
6. Remainder (14 minus 15)		1,315
7. Countable earned inc. (divide 16 by 2)		657.50
8. Total countable inc (add 10 and 17)		657.50

C. EXEMPT INCOME

II. INCOME OF MFBU MEMBERS OR PERSONS RESPONSIBLE FOR THE MFBU NOT LISTED IN I. (EXCEPT PA OR OTHER PA)

A. NONEXEMPT UNEARNED INCOME

1. Social Security	
2 Net income from property	
3. Other—Itemize	
4	
5 Total unearned inc. (add 1 through 4)	
6. Deductions	
7 Countable unearned inc (5 minus 6)	

B. NONEXEMPT EARNED INCOME

8 Gross earned inc	
9. If CG in last 4 months a. enter $30	
b. ⅓ Remainder	
10. Mand. deduct	
11. W/R expenses	
12 Total earned inc, deductions (add 9, 10, 11)	
13 Countable earned inc. (8 minus 12)	
14 Total countable inc (add 7 and 13)	

III. SHARE OF COST COMPUTATION

1 Countable income from I 18	
2. Countable income from II 14	
3. Combined countable income (add 1 and 2)	657.50

ALLOCATIONS AND DEDUCTIONS

4 Inc allocated from LTC person to family members at home (176W, Part IV)	
5 Total countable income (add 3 and 4)	657.50
6 Allocation from LTC income (176W, Part IV)	
7 Allocation to stepparent unit (176W, Part V)	
8 Allocation to excluded family members (176W Part I)	
9. Special deduction (176W, Part II)	116.50
10 Income to determine PA eligibility	
11. Health insurance	
12 Child support	
13 Total allocations/deductions (add 6 through 12)	116.50
14. Total net nonexempt income (5 minus 13)	541
15. Total net nonexempt income rounded	541
16 Maintenance need	
a MFBU members not in LTC No. 2	383
b. MFBU members in LTC • Personal needs • Upkeep of home • Needs of disabled dependents	
c Total maintenance need (16a + 16b)	383
17 Share of cost (15 minus 16)	158
18. Underpayment adjustment	116
19. Adjusted share of cost (17 minus 18)	42

State of California—Health and Welfare Agency
Medi-Cal Program

"ADJUSTMENT BILLED"

ATTACHMENT IV

Department of Hea

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

CO DIST	COUNTY USE
23	1484567

Only Medical expenses in the following month may be listed below.	Share of Cost: The amount that you must pay or obligate is:	Page of / Retro. Elig?
10/73 Mo. Yr.	$ 42.00	No (Yes/No)

Name: Helen Of Troy
Address: 12345 Greek Street
City/State/Zip: Peanutville, Ca 55555

County Code: 23

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No	FBU	Pers.	Name — Last, First	B	A	Birthdate Mo. Day Yr.	Sex	Other Cov. Code	Social Security No.	HIC or RR No.
14	0000000	0	60	Troy, William Of			7/5/13	M	A	561-42-0000	
84	0000000	0	50	Troy, Helen Of			1/20/19	F	A	543-16-0000	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or other third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME / PATIENT NAME / PROVIDER SIGNATURE (See Declaration Above)	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
Ronald Reagan / William Of Troy	XYA 777	10	5	79	Surgery	8524	942	42	900

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By:	Trans	Replace
10	5	78			

Date of Certification

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed under the "Billed Patient" column.

X William Of Troy 5/31/7
SIGNATURE OF APPLICANT DATE

MC 177—S (1/78)

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING.

State of California—Health and Welfare Agency
Medi-Cal Program

"ADJUST PREVIOUS CLAIMS"

ATTACHMENT V

Department of Health

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

CO DIST	COUNTY USE
23	1484567

Only Medical expenses in the following month may be listed below.	Share of Cost: The amount that you must pay or obligate is.	Page of	Retro Elig?
10/73 Mo. Yr.	$ 42.00		No (Yes/No)

Name: Helen Of Troy
Address: 12345 Greek Street
City/State/Zip: Peanutville, Ca 55555

County Code: 23

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No	FBU	Pers.	Name — Last, First	B	A	Birthdate Mo. Day Yr.	Sex	Other Cov. Code	Social Security No	HIC or RR No.
14	0000000	0	60	Troy, William Of			7/5/13	M	A	561-42-0000	
84	0000000	0	50	Troy, Helen Of			1/20/19	F	A	543-16-0000	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or other third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME / PATIENT NAME / PROVIDER SIGNATURE (See Declaration Above)	Provider No.	Date of Service Mo.	Day	Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
Ronald Reagan / William Of Troy	XYA 777	10	5	79	Surgery	8524	942	42	900

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By	Trans.	Replace
10	5	78			

Date of Certification

I have read the [illegible] on the back of this form. I agree to assume full legal responsibility for the amounts listed as Billed Patient [illegible]

X William Of Troy 5/30/79
SIGNATURE OF APPLICANT DATE

State of California—Health and Welfare Agency
Medi-Cal Program

"ADJUSTMENT -- NOT BILLED"

ATTACHMENT VI
Department of Health

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

CO DIST	COUNTY USE
23	1484567

Only Medical expenses in the following month were incurred below.	Share of Cost The amount that you must pay or obligate is:	Page of	Retro. Elig?
10/73 Mo. Yr.	$ 42.00)		No (Yes/No)

Name: Helen Of Troy
Address: 12345 Greek Street
City/State/Zip: Peanutville, Ca 55555

County Code: 23

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No	FBU	Pers.	Name – Last, First	B	A	Birthdate Mo. Day Yr.	Sex	Other Cov. Code	Social Security No.	HIC or RR No.
14	0000000	0	60	Troy, William Of			7/5/13	M	A	561-42-0000	
84	0000000	0	50	Troy, Helen Of			1/20/19	F	A	543-16-0000	

Declaration of Provider Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or other third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME / PATIENT NAME / PROVIDER SIGNATURE (See Declaration Above)	Provider No.	Date of Service Mo. Day Yr.	SERVICE	Proc. Code/ Presc. No.	Total Bill $	Billed Patient $	Billed Medi-Cal $
Ronald Reagan / William Of Troy	XYA 777	10 5 79	Surgery	8524	942	42	900

STATE USE ONLY

Mo.	Day	Yr.	Reviewed By:	Trans.	Replace
10	5	78			

Date of Certification

I have read the ... agree to assume full legal responsibility for the amounts ... billed Medi-Cal.

X William Of Troy 8/30/7
SIGNATURE OF APPLICANT DATE

MC 177—5 (1/78)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1797

September 4, 1979

To: County Welfare Directors of Fresno, Imperial, Kern, Los Angeles, Marin, Mendocino, Merced, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo, and Yuba.

INDOCHINESE REFUGEE ASSISTANCE PROGRAM (IRAP) REPORTING REQUIREMENTS

As you know, more and more Indochinese refugees are coming to California from refugee camps in Southeast Asia, and are applying for cash and medical assistance under the AFDC and Medi-Cal-only programs. In order to claim special federal refugee funds for their Medi-Cal costs, we must know which Medi-Cal recipients are also refugees. A reporting procedure, described in the Department's Medi-Cal All-County Letter dated July 19, 1978 (copy attached), was set up to provide the Department of Health Services (DHS) with identification of IRAP AFDC recipients as well as identification of IRAP Medi-Cal-only eligibles. However this reporting procedure for refugee Medi-Cal recipients no longer appears to be functioning successfully in all counties.

Problem Identification

The state Department of Social Services (DSS) requires counties to separately identify IRAP AFDC recipients in county internal files, in order to provide total IRAP person counts to DSS. By comparing the AFDC cash refugee totals reported to DSS by counties for December 1978 against the number of AFDC cash refugees which DHS shows as eligible for December, it appears that over 4,500 persons who were new IRAP AFDC recipients for that month were not reported to DHS. Underreporting of refugee Medi-Cal-only eligibles also appears to be a problem based on the facts that 1) there has been a substantial reduction in the volume of reports identifying new refugees who are receiving Medi-Cal, and 2) at the same time the number of refugees entering California is increasing rapidly.

Impact of Problem

Medi-Cal process for reporting both IRAP AFDC and Medi-Cal-only refugees requires counties to report each refugee to DHS only once. This procedure minimizes the reporting workload on counties. However, if it is not followed, the effect of non-reporting of refugees multiplies; if the reporting is not done when a refugee first comes on the AFDC or Medi-Cal-only programs, it probably will not occur at all. As a result, the refugee may receive Medi-Cal benefits month after month, and none of the costs will receive special refugee funding.

For 1979, the volume of new refugees entering California who would receive AFDC cash or Medi-Cal-only was originally projected to be approximately

1,700 per month. Since this projection, the Federal Government has increased the number of refugees who may be admitted to the United States from 7,000 to 14,000 per month. With this large potential increase in refugees expected to enter California, accurate federal claiming becomes even more important. Because such a large number of IRAPS were not reported in December 1978, we are concerned that even more might have been overlooked in the succeeding months.

The claiming of federal refugee funds for Medi-Cal expenditures requires special computer processing. This special processing has been suspended in order to avoid rerunning each month's processing once the unreported AFDC and Medi-Cal-only refugees are reported to the Department. As a result our federal refugee claiming system is in abeyance until the reporting problems are resolved.

Problem Resolution

It is necessary to determine to what extent underreporting has occurred in your county. We are requesting that you determine whether all Indochinese refugee recipients of both the AFDC and the Medi-Cal-only programs have been reported to DHS for each month beginning with December 1978 to the present. Because it is important to act as quickly as possible, we are requesting you to report these findings to your county's Medi-Cal field representative by September 21, 1979. If it is determined that there is a reporting problem in your county, we will work with you to define the steps necessary to resolve the problem.

If you have any questions or desire further information, please contact your Medi-Cal field representative on my staff at (916) 445-1912.

Sincerely,

Doris Z. Soderberg

Doris Z. Soderberg, Chief
Eligibility Branch

Attachment
cc: Medi-Cal Liaisons
Medi-Cal Field Representatives